Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN5750PCA	A. BUILDING _____ B. WING _____	10/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INTERIM HOMESTYLE SERVICES	**1950 COLLEGE PARKWAY, SUITE 101 CARSON CITY, NV 89706**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
P 000	Initial Comments Surveyor: 28436 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The agency had applied for a license as a Personal Care Aide Agency which provides in-home personal care services to elderly and disabled persons. This Statement of Deficiencies was generated as a result of the initial State Licensure survey conducted at your agency on October 27, 2009. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division, in accordance with Nevada Administrative Code, Chapter 449, Personal Care Agencies. No regulatory deficiencies were identified. Please keep a copy of the statement for your records. No further action is required.	P 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE